A

KRISHNAN NAMBIAR PERABAKARAN & ORS

v.

DR P MAHENDRAN & ANOR

B

HIGH COURT MALAYA, MELAKA
LOW HOP BING J
[CIVIL SUIT NO: 22-253-1999]
12 DECEMBER 2008

C

TORT: *Negligence - Medical negligence - Brain damage to baby after delivery - Whether due to negligence of doctor - Whether causation established*

EVIDENCE: *Adverse inference - Failure of defence to call material witness - Whether adverse inference could be drawn - Evidence Act 1950, s. 114(g)*

D

EVIDENCE: *Expert evidence - Admissibility of - Medical negligence - Evidence of treating doctor training to be paediatrician at material time - Whether independent witness - Whether evidence admissible*

This was the plaintiffs' claim for damages against the defendants on medical negligence. The plaintiffs' alleged that the 1st plaintiff who was
E a baby and whose father (the 2nd plaintiff) was suing on his behalf, suffered severe brain damage diagnosed as Hypoxic Ischaemic Encephalopathy (HIE) after delivery by the mother (the 3rd plaintiff). The baby was born in Asia Clinic (the 2nd defendant) and was under the care, control and supervision of one Dr Mahendran (1st defendant).
F The plaintiffs' claimed that the defendants failed to call two material witnesses, one Dr Manon Mani and one Dato Dr Nagaratnam and as such urged the court to draw an adverse inference against the defendants under s. 114(g) of the Evidence Act 1950 ('EA'). On the other hand, the defendants challenged the evidence of one Dr Soh on the ground
G that he was a treating doctor training to be a paediatrician at the material time and as such, could not be regarded as an independant witness.

Held (dismissing the plaintiffs' claim):

(1) In s. 114(g) EA, the most important word was "withholds". The
H adverse inference thereunder was not mandatory but discretionary having regard to the relevancy and materiality of a particular witness. Withholding and/or suppression of evidence was *sine qua non*. A mere failure or non-production *per se* was insufficient. In the absence of the defendants withholding or the defendants' suppression
I of evidence, no adverse presumption should be drawn against the defendants under s. 114(g). (para 9)

(2) Section 101 EA provided for the burden of proof. Section 101 specifically stated that whoever desired any court to give judgment as to any legal right or liability, dependant on the existence of facts that he asserted must prove that those facts existed. (para 11)

(3) The plaintiff on whom the burden of proof lies had unrestricted access to the said witnesses. There was no property in any particular witness. Any party was at liberty and entitled to compel their attendance by subpoena. If the plaintiffs were of the view that Dr Manon Mani was supportive of the plaintiffs' case, then the plaintiffs should have called her to testify. As to Dato' Dr Nagaratnam, the evidence adduced at the protracted trial showed no trace of his involvement in the events on the material dates. A witness was only useful and might be appropriately called to testify and assist the court if his evidence was likely to be material and relevant. Otherwise, the evidence was not admissible. (paras 12 & 13)

(4) It was noted that none of the defendants' witnesses testified that Dr Soh's findings lacked objectivity. There was no prohibition in law that a treating doctor could not give evidence. There was also no presumption in law that a treating doctor's testimony lacked objectivity. Hence, the opinion of the doctor who had actually examined the injured person should be preferred to that of the other doctor that was based on the injury and X-ray reports. In the circumstances, the fact that Dr Soh was the treating doctor and training to be a paediatrician at the material time and place did not *ipso facto* disqualify him from giving evidence. His evidence was admissible and should be given due credence in the absence of cogent reasons to the contrary. (paras 17, 18, 19 & 20)

(5) The facts and evidence adduced showed that the baby was fine and in good condition at birth. Whilst it was not disputed that the baby's defects occurred in Asia Clinic, medical evidence showed that the cause of the baby's brain damage was not known. The evidence of one Prof Ho was singularly significant. She doubted that brain damage or cerebral palsy was established. (paras 30 & 38)

(6) The various opinions expressed in the evidence adduced from all the medical witnesses were somewhat divided and not unanimous. Their opinions did not show that the phenergan, fortum, dextrose and the Ryles' Tube feeding given by Dr Mahendran was the real and substantial cause of the baby's brain damage. No liability could be established if no harm was caused in the first place as demonstrated in and confirmed by the evidence of Dr Soh for the plaintiffs and

A one Dr Ng for the defendants. What and who had really and substantially caused the baby's defects, in particular HIE with development delay remained unresolved at the conclusion of the trial. In the circumstances, the plaintiffs failed to establish causation on a balance of probabilities. (para 40)

B **Case(s) referred to:**
Industrial Concrete Products Bhd v. Concrete Engineering Products Bhd [2001] 8 CLJ 262 HC ***(refd)***
Lau Song Seng & Ors v. PP [1998] 1 SLR 663 ***(refd)***
MBF Finance Bhd v. Sim Peng Bee & Anor [2003] 1 CLJ 690 HC ***(refd)***
C *Munusamy v. PP [1987] 1 MLJ 492* ***(refd)***
Nuri Asia Sdn Bhd v. Fosis Corp Sdn Bhd & Anor [2006] 5 CLJ 307 HC ***(refd)***
Pekan Nenas Industries Sdn Bhd v. Chang Ching Chuen & Ors [1998] 1 CLJ 793 FC ***(refd)***
Tanviben Pankajkumar Devetia v. State of Gujarat, A [1997] SC 2193 ***(refd)***
Tenaga Nasional Berhad v. Perwaja Steel Sdn Bhd [1995] 4 CLJ 670 HC ***(refd)***
D *Tindok Besar Estate Sdn Bhd v. Tinjar Co [1979] 1 LNS 119 FC* ***(refd)***

Legislation referred to:
Evidence Act 1950, ss. 101(1), 114(g)

Other source(s) referred to:
E *Sarkar on Evidence*, 15th edn, 1999 vol 1, pp 901, 902

For the plaintiffs - Sri Murugan; M/s M Manoharan & Co
For the defendants - PS Ranjan (MS Dhillon with him); M/s PS Ranjan & Co

Reported by Usha Thiagarajah

F

JUDGMENT

Low Hop Bing J:

G **Introduction**

[1] The complexity of this civil action is unfolded by lay and medical witnesses who testified in these protracted proceedings. The evaluation of their evidence is no doubt time consuming. The consideration and
H analysis of medical evidence and literature is equally formidable.

Plaintiffs' Claim

[2] The plaintiffs' action against the first and second defendants is based on medical negligence. The first plaintiff ("the baby") sues by his
I father who is the second plaintiff (SP1) ("the father"). The baby's mother is the third plaintiff ("the mother").

[3] The crux of the plaintiffs' statement of claim is that the the baby was not a healthy normal baby at birth, but with defects, caused by the negligence of the defendants, as a result of which the baby had suffered severe brain damage which three doctors later diagnosed as "Hypoxic Ischaemic Encephalopathy (H.I.E.) with developmental delay". The three doctors are:

(1) SP2 (Dr. Soh Chau Peng) a paediatrician in the Melaka Hospital at the material time, and subsequently in private practice attached to the Kluang Utama Specialist Centre;

(2) SP6 (Dr. Kuan Geok Lan) a consultant paediatrician attached to the Melaka Hospital; and

(3) SP5 (Dr. Mohd Khairi b Mat Aris) a consultant paediatrician based in the Johor Specialist Hospital.

Burden Of Proof

[4] The burden is on the plaintiffs to prove that the defendants had acted in breach of their duty of care, thereby causing damage to the baby in particular and the other plaintiffs in general; and that the damage was reasonably foreseeable.

[5] I shall now consider the issue pertaining to the defendants' failure to call witnesses, as this issue is closely connected with the burden of proof.

Failure To Call Witnesses

[6] Plaintiffs' learned counsel Mr. Sri Murugan raised the issue of the defendants' duty to call two material witnesses *viz*. Dr. V Manon Mani of Jabatan Rawatan Perubatan Utama Hospital University and Dato Dr. K Nagaratnam of Asia Clinic. The plaintiffs argued that Dr. Mahendran has referred the baby to Dr. V. Manon Mani, while Dato Dr. K Nagaratnam could verify as to whether Dr. Mahendran is indeed a partner in Asia Clinic, because Dr. Mahendran is a bankrupt. He urged the court to draw adverse inference against the defendants under s. 114(g) of the Evidence Act 1950.

[7] The response of the defendants' learned counsel Mr. PS Ranjan (assisted by Mr. MS Dhillon) is that s. 114(g) is inapplicable as the burden is on the plaintiff to prove their case against the defendants.

[8] In my judgment s. 114(g), where relevant, merits reproduction as follows:

> 114. Court may presume existence of certain fact
>
> The Court may presume the existence of any fact which it thinks likely to have happened, regard being had to the common course of natural events, human conduct, and public and private business, in their relation to the facts of the particular case.
>
> Illustrations
>
> (g): that evidence which could be and is not produced would if produced be unfavourable to the person who withholds it;

[9] Lest it be misunderstood, I find it necessary to reaffirm the law contained in s. 114(g). I shall enumerate the relevant principles as follows:

(1) The single most important word therein is "withholds";

(2) The adverse inference thereunder is not mandatory but discretionary, having regard to the relevancy and materiality of a particular witness: see *Lau Song Seng & Ors v. Public Prosecutor* [1998] 1 SLR 663 Singapore CA; and

(3) Withholding or suppression of material evidence is a *sine qua non*; a mere failure or non-production *per se* is insufficient: see eg, *Munusamy v. Public Prosecutor* [1987] 1 MLJ 492, 494 SC per Mohamed Azmi SCJ (as he then was); and *Pekan Nenas Industries Sdn Bhd v. Chang Ching Chuen & Ors* [1998] 1 CLJ 793 FC per Edgar Joseph Jr FCJ (as he then was).

[10] In the absence of defendants' withholding or suppression of evidence, no adverse presumption may be drawn against the defendants under s. 114(g).

[11] It is noteworthy that s. 101 of the Evidence Act 1950 provides for the burden of proof. Section 101(1) specifically states that whoever desires any court to give judgment as to any legal right or liability, dependent on the existence of facts which he asserts, must prove that those facts exist: see eg, *Tenaga Nasional Berhad (Formerly Lembaga Letrik Negara Tanah Melayu) v. Perwaja Steel Sdn Bhd (Formerly Perwaja Terengganu Sdn. Bhd.)* [1995] 4 CLJ 670 HC; *MBF Finance Bhd v. Sim Peng Bee & Anor* [2003] 1 CLJ 690 HC; and *Nuri Asia Sdn Bhd v. Fosis Corp Sdn Bhd & Anor* [2006] 5 CLJ 307 HC.

[12] The plaintiffs on whom the burden of proof lies has unrestricted access to the aforesaid two witnesses. There is no property in any particular witness. Any party is at liberty and indeed entitled to compel their attendance by subpoena. If the plaintiffs are of the view that Dr. V. Manon Mani is supportive of the plaintiffs' case, the plaintiffs should have called her to testify.

[13] In the case of Dato' Dr. K. Nagaratnam, the evidence adduced at the protracted trial shows no trace of his involvement in the events on 4 and 5 July 1996 at Asia Clinic. It is trite law that a witness is only useful and may appropriately be called to testify and assist the court if his evidence is likely to be material and relevant. Otherwise, the evidence is not even admissible. It serves no purpose just to call a witness to satisfy or quench the curiousity of a party.

Admissibility Of Evidence

[14] At this juncture, it is pertinent to resolve the admissibility of the evidence of Dr. Soh Chau Peng.

[15] Defendants mounted a challenge on Dr. Soh's evidence on the ground that he was at the material time a treating doctor who was training to be a paediatrician at the Melaka Hospital and cannot properly be regarded as an independent witness.

[16] It was the plaintiffs' submission that Dr. Soh's evidence is admissible and should be given due weight.

[17] In my view, it needs to be noted that none of the defendants' witnesses testified that Dr. Soh's findings lack objectivity.

[18] There is no prohibition in law that a treating doctor cannot give evidence. There is also no presumption in law that a treating doctor's testimony lacks objectivity. My view is fortified by the following passage in *Sarkar on Evidence* 15th edn, 1999 vol. 1, pp. 901 and 902:

> When medical men who attended the patient during his illness give their testimony as to the bodily or mental state of the deceased, their evidence is not that of experts but of men who have observed relevant facts and whose evidence derives an enchanced value from the circumstances that there are favourable opportunities, peculiar facility and obvious incentives for accurate observation and that their training would fit them to appreciate and describe what they observed (*Goppessur v. Bissessur*, 16 CWN 265, 273)

[19] Hence, the opinion of the doctor who had actually examined the injured person should be preferred to the opinion of the other doctor which was based on the injury report and the X-ray report without even looking to the X-ray plate: see *Tanviben Pankajkumar Devetia v. State of Gujarat*, A [1997] SC 2193; [1997] Cri LJ 2535, 2550.

[20] In the circumstances, the fact that Dr. Soh was the treating doctor and training to be a paediatrician at the Melaka Hospital does not *ipso facto* disqualify him from giving evidence. I hold that his evidence is admissible and should therefore be given due credence, in the absence of cogent reasons to the contrary.

Baby's Condition At Birth

[21] The plaintiffs maintained that the baby was not born healthy and normal and blamed the defendants for this.

[22] The defendants contended that at birth, the baby had an Apgar score of ten and was healthy and normal.

[23] In my judgment, the question ie, whether the baby was born healthy and normal is a question of fact. The answer to this question is to be ascertained by reference to the evidence in relation to the events which took place from 3.39pm on 4 July 1996 when the baby was delivered at birth and the events substantially contemporaneous thereto.

[24] When the baby was born at 3.39pm on 4 July 1996 in Asia Clinic (the second defendant), the baby was under the care, control and supervision of the first defendant, Dr. P. Mahendran.

[25] The father, who saw the baby at birth, testified that:

(i) The baby's hand, feet and face were "bluish in colour" and was placed outside the delivery room;

(ii) The baby was not moving and never cried in Asia Clinic as he only heard the baby cry for the first time in the Melaka Hospital;

(iii) No oxygen was given to the baby on 4 July 1996, as he did not see any tube fixed to the baby in Asia Clinic, from 4 July 1996 to the subsequent transfer on 5 July 1996, to the Melaka Hospital;

(iv) On 4 July 1996 between 4 and 4.30pm, when he enquired about the baby's condition, Dr. Mahendran informed him that the baby was fine;

(v) He never saw Dr. Mahendran in Asia Clinic after that as the nurse there informed him that Dr. Mahendran was on leave from 5 to 8 July 1996;

(vi) He was not happy with the care and treatment given by Dr. Mahendran because the latter had not done anything for the baby;

(vii) The second defendant did not have the necessary medical equipment nor a resident paediatrician to treat the ill new-born baby, thereby rendering it necessary to transfer the baby to Melaka Hospital on 5 July 1996, after the father had received a call from a nurse in Asia Clinic that the baby was in a serious condition;

(viii) He and his wife (the third plaintiff) were asked whether the baby was to be sent to the Melaka Hospital or the private Southern Hospital; and

(ix) The baby suffered injury requiring full time supervision, physiotherapy and attention in a special school.

[26] The mother testified that after birth:

(i) She never saw the baby at all in Asia Clinic but was told that the baby was in good condition;

(ii) She only saw the baby for the first time in the Melaka Hospital on 8 July 1996, four days after birth, when she was discharged, after Dr. Mahendran returned from his leave; and

(iii) Dr. Mahendran only saw her twice, *viz* on 4 July 1996 when delivering the baby, and on 8 July 1996 when she was discharged.

[27] The evidence adduced for the defendants revealed that Dr. Mahendran had told the father and the mother that their baby was fine and in good condition at birth. Dr. Mahendran's medical notes recorded that the baby at birth had an Apgar score of ten which the father and the mother doubted.

[28] Being faced with these two conflicting versions, it is my duty to ascertain which version is the more probable, and to arrive at a specific finding of fact. In this regard, it is appropriate for me to follow the safer approach set out by Chang Min Tat FJ (as he then was) for the Federal Court in *Tindok Besar Estate Sdn. Bhd. v. Tinjar Co.* [1979] 1 LNS 119, ie, to refer to and rely on the witness' acts and deeds which were contemporaneous with the event and to draw reasonable inferences from them, adding that judicial reception of evidence requires that the oral evidence be critically tested against the whole of the other evidence and circumstances of the case, and that plausibility should never be mistaken for veracity.

[29] The above approach was also applied by James Foong J (now JCA) in *Industrial Concrete Products Bhd v. Concrete Engineering Products Bhd* [2001] 8 CLJ 262 HC; and by me in *Nuri Asia Sdn*, *supra*.

[30] The evidence of the father and the mother to the effect that they were informed that at birth their baby was fine and in good condition had not been qualified by any ring of untruth in that information. Next, Dr. Mahendran's contemporaneous medical notes, which recorded that the baby was born with an Apgar score of ten, indicating that the baby was born normal and healthy, had not been shown to have been doctored. In the circumstances, I accept the defendants' version as being more probable, and answer the above question in the affirmative.

Phenergan, Fortum, Dextrose And Ryles' Tube Feeding

[31] It was submitted for the plaintiffs that:

(i) "Phenergan" (the scientific name) or "promethazine" (the generic name), being a cough syrup, is generally used to treat cough and sometimes vomiting, but not given for twitching;

(ii) Medical witnesses, namely Dr. Soh; Dr. Kuan; Dr. Ng Kok Chai (DW2), a paediatrician in private practice attached to Southern Hospital Melaka; Dr. Ong Mean Choon (DW5), a consultant obstetrician and gynaecology; and Prof Jacqueline Ho (DW6) unanimously testified that phenergan is not given to a new born baby at any cost;

(iii) Phenergan can still be present in the body up to 12 hours in children, based on Dr. Kuan's evidence and Forfar and Arneil's Textbook of Paediatrics at p. 2019, particularly at the 5th column, where it clearly prohibits a doctor from giving promethazine to any person below one month;

(iv) The clinical notes of Asia Clinic and Dr. Mahendran's medical report clearly state that 1cc of "syrup phenergan" was given to the baby at 10.30am on 5 July 1996;

(v) A causal link is established between the giving of phenergan and the brain damage suffered by the baby;

(vi) *Dr. Mahendran*'s care and management of the baby is highly deplorable in that Dr. Mahendran had literally abandoned the baby at 10.30am on 5 July 1996, after giving phenergan;

(vii) Pending the arrival of Dr. Ng, Dr. Mahendran made no record of any further observation on the condition of the critically ill baby;

(viii) Dr. Mahendran did not see Dr. Ng on 5 July 1996; and

(ix) Dr. Mahendran had caused the H.I.E. with developmental delay in the baby, as a result of giving phenergan, fortum, dextrose and Ryles' Tube feeding.

[32] It was contended for the defendants that: A

(i) the issue is not whether the giving of phenergan, fortum, dextrose and Ryles' Tube feeding could have caused brain damage, but whether the defendant had in fact caused H.I.E. with developmental delay; and B

(ii) the plaintiffs have failed to discharge the burden of proof.

[33] From these conflicting submissions, I identify the question for determination as follows:

> Whether the phenergan, fortum, dextrose and Ryles' Tube feeding given by Dr. Mahendran (the first defendant) to the baby was the real and substantial cause of the baby's H.I.E. with developmental delay? C

[34] The answer to this question is to be ascertained by reference to the evidence of the relevant medical witnesses, *viz* Dr. Soh and Dr. Kuan for the plaintiffs; and Dr. Ng, Dr. Ong and Prof Ho for the defendants. D

[35] I shall now evaluate and enumerate their evidence below:

Dr. Soh E

(a) Phenergan should not be given to any child below two years, as it will cause sleepiness or drowsiness, impair breathing, and may even cause sudden death;

(b) Phenergan can impair the baby's breathing, cause further lack of oxygen and damage to the brain, on the authority of an article published by Wyeth - Ayerst Laboratories under the heading "Paediatric Use", where it was stated that this product should not be used in children under two years of age because safety for such use has not been established; F G

(c) However, in the Melaka Hospital, he (Dr. Soh) had prescribed to the baby 2ml phenergan three times a day for three days and although it was more than the 1cc of phenergan given once by Dr. Mahendran on 5 July 1996, the baby suffered no ill effects as a result; H

(d) Phenergan may properly be given to a new born baby for a medical purpose and he saw no harmful effect of the phenergan;

(e) Feeding solution into the stomach may not be absorbed by the baby; I

(f) Intravenous solution given intravenously is the proper management; and so Ryles' Tube feeding was an option;

(g) Our blood is red in colour when there is enough oxygen and when oxygen is inadequate, the colour is blue; it will cause bluish appearance on a person; and that is known as cyanosis.

(h) The baby was "critically ill" at 5pm on 4 July 1996 when cyanosis was noted and someone who is competent should have been called to manage the baby, but a paediatrician was only called to see the baby on the following day, 5 July 1996 at 12.30pm.

(i) The delay of 19 1/2 hours from 5pm 4 July 1996 to 12.30pm on 5 July 1996 in giving proper care to a critically ill brain-damaged baby can cause further injury to the baby's brain;

(j) The paediatrician should have been called when the cyanosis was noted at 5pm on 4 July 1996;

(k) Looking retrospectively, the child should have been referred soon after the symptoms started.

(l) No breast feeding took place in Asia Clinic. The baby was fed *via* Ryles' Tube since 5pm on 4 July 1996 until 2pm on 5 July 1996;

(m) Dr. Mahendran had instructed that all oral feeding be stopped;

(n) The baby was given strong dose of antibiotics ie, 100mg of fortum, on 4 July 1996 and 1cc of fortum on 5 July 1996. The baby was given oxygen *via* a head box. The baby was given 10% dextrose every half hour instead of milk which is more nutritious;

(o) Slight twitching of limbs was observed at 10.30am on 5 July 1996;

(p) The baby had a temperature of 99.6°F on 5 July 1996 at 10.30am. Condition remained the same until 12.30pm on 5 July 1996 and the paediatrician was informed of the baby's critical condition at 11am on the same day; and

(q) The baby's condition became worse at 10.30am on 5 July 1996.

Dr. Kuan

(a) It was strange to give a high dose ie, 1cc of phenergan which is equivalent to 5mg on the second day of life when twitching was observed and, in her experience, phenergan can result in respiratory depression;

(b) 1cc was given but there was no mention of dilution in the strength;

(c) The effect of overdosage of phenergan is explained in an article published by Wyeth-Ayerst Laboratories as follows:

> Overdosage
>
> Signs and symptoms of overdosage with promethazine range from mild depression of the central nervous system and cardiovascular system to profound hypotension, respiratory depression, and unconsciousness;

(d) Dextrose was given half hourly to the baby who vomited at 45 minutes of life, turned cyanose at 1 1/2 hours of life, and continued to be given the next, despite the observation that the baby had twitching of the lower limbs;

(e) This dose of 2cc of antibiotics amounting to 420mg given at two hours of life and 14 hours of life far exceeded the dose the baby requires ie, 140mg based on his birth weight;

(f) The 5mls of syrup phenergan ie, 25mg of promethazine hydrochloride is not recommended for children less than two years of age;

(g) In relation to the episode of vomiting and slight cyanosis:

(i) The baby was not treated appropriately;

(ii) The baby was unwell; hence vomiting and cyanosis could have subtle seizures;

(iii) When babies vomit, doctors don't feed them even with Ryles' Tube, nor start antibiotic injection without investigating;

(iv) With the benefit of the clinical notes, for Dr. Mahendran, MRCOG with MD (Oxford), to have prescribed antibiotics at two hours of life is going beyond his professional training, and that medical qualification does not prepare the holder for the care of new born babies;

(h) For Dr. Mahendran to have given antibiotics at 5.30pm, it can only be assumed that Dr. Mahendran held that the baby was unwell; and that Dr. Mahendran under-estimated the clinical condition of the baby;

(i) The trend of events on 4 July 1996, *viz* the vomiting at 4.45pm and an epidose of cyanosis at 5pm, should have alerted Dr. Mahendran that not all was well with the baby;

(j) There is delayed referral because on 4 July 1996, the baby was stated to have vomited at 4.45pm and to be cyanosed at 5pm If Dr. Ng had been called, perhaps the child could have been referred earlier; and

(k) Dr. Mahendran's conduct in giving Ryles' Tube feeding and antibiotics only delayed the referral to the Melaka Hospital.

Dr. Ng

(a) It is not proper to give 1cc of syrup phenergan to the baby;

(b) However, the phenergan had caused no harm to the baby;

(c) Giving 1cc of syrup phenergan to the baby is an outdated treatment, although it had caused no harm; and

(d) The baby's twitching and body temperature of 99.6°F on 5 July 1996 at 10.30am was serious.

Dr. Ong

(a) Phenergan is only used on adults, as an anti-histamine, sedative and anti vomiting agent;

(b) He had never used the drug for a new born baby;

(c) Fortum is a strong form of antibiotics and there was no indication of the baby suffering from any infection;

(d) Hence, assuming the baby is born healthy with an Apgar score of ten, in principle, there was no necessity to give antibiotics to prevent infection;

(e) If a baby has an Apgar score of ten, there would be no necessity to give antibiotics and oxygen via head box. In this case, oxygen commenced at 5pm on 4 July 1996 at 4.50pm ie, 1 hour 11 minutes after birth and this continued until the baby was taken to the Melaka Hospital, and that if the baby is normal, Ryles' Tube feeding would not be necessary; and

(f) On 5 July 1996 at 10.30a.m. the slight twitching of lower limbs in the second day of life would not be considered normal.

Prof Ho

(a) Phenergan is a mild sedative generally used for allergy, vomiting and drying of secretion;

(b) It is not an established medical practice to give phenergan to a neonate below 28 days of life;

(c) It is completely beyond her experience both here and during her United Kingdom and Australia training to hear of the use of phenergan by Dr. Mahendran in thousands of neonates in the dosage of 0.5mg/ml without problems;

(d) Phenergan may lower the threshold for seizures and an overdosage may rarely cause seizure;

(e) She would not know whether 1cc of undiluted syrup phenergan given to a 2.8kg baby is an overdosage;

(f) The Melaka Hospital record (exh. P4) states that on admission, the baby had "starry eye" which could be due to neonatal encephalopathy or the effects of drugs, but the records do not show whether the cause was established;

(g) Ryles' Tube feeding is unsafe to a new born baby because the risk of fluid entering the lung can occur; the baby could choke and be deprived of oxygen, thereby causing brain damage if the hypoxia is long enough.

(h) An Apgar score of ten implies that the baby has the ability to cry on birth;

(i) The appropriate time to take care and management of the baby is when twitching occurred at 10.30am on 5 July 1996 and that was something to be concerned with, as twitching is a medical emergency;

(j) Twitching in a new born may be due to many causes, namely low blood sugar, injury to the brain, congenital abnormality of the brain and meningitis;

(k) Considering the state of delayed development described by Dr. Mohd Khairi, there is no sufficient evidence of cerebral palsy;

(i) In the absence of cerebral palsy or mental retardation, there is a wide range of causes, but not including H.I.E.;

(m) If this is a case of mental retardation, without confirmation of cerebral palsy, she would not accept H.I.E. as a diagnosis in this case.

(n) Prof Ho's evidence is supported by an article "Inter-partem Hypoxic-lschaemic cerebral injury and subsequent cerebral palsy: Medical Legal Issues in "Pediatrics" Vol. 99 No. 6 June 1997 (P2) the relevant portion reads as follows:

> There is increasing evidence that in most cases the brain injury associated with cerebral palsy is **not related to perinatal events**.
>
> As noted previously, the genesis of hypoxic - ischaemic cerebral injury in most cases of cerebral palsy is **before labour and delivery** ...
>
> Perinatal hypoxic-ischaemic cerebral injury, secondary to intrapartum asphyxia, resulting in crerbral palsy, is a *rare event* in most delivery rooms and neonatal intensive care nurseries.
>
> Lastly, it is clear that individual cases of cerebral palsy and other forms of adverse pregnancy outcomes are in most cases **unlikely** to have been caused by **suboptimal obstetric** care as defined in this study. (emphasis added)

[36] There is also evidence that the Melaka Hospital had given phenergan to the baby and the baby had developed apnoea and respiratory depression requiring intensive care, including ventilation. There was no respiratory depression when the baby was admitted to the Melaka Hospital. Apnoeic spells occurred after admission, the first at 11.05pm on 5 July 1996, after the baby was given the three powerful drugs at the Melaka Hospital.

[37] Ryles' Tube feeding was commenced after the cyanosis was treated. There is no evidence that thereafter the baby choked or suffered apnoeic spells. On the night of 5 July 1996, the baby's condition was noted to be "good", "colour good", and crying normal". The next day, the single episode of twitching occurred. There was no problem of choking recorded at Asia Clinic. The baby was fed, observed and remained under the care of the first defendant and the nurses at Asia Clinic.

[38] Having evaluated and enumerated the above evidence, I am of the view that while it is not disputed that the baby's defects occurred in Asia Clinic, medical evidence shows that the cause of the baby's brain damage was not known. I find that the evidence of Prof Ho is singularly significant. She doubted that brain damage or cerebral palsy was even established.

[39] The article *"Only a minor part of cerebral palsy begin in labour"* British Medical Journal Vol 319 16 October 1999 contains the following passage:

> The common assumption is that perinatal asphyxia is the usual cause of cerebral palsy in ... babies ... There is **no evidence that current obstetric practices can reduce the risk of cerebral palsy. The origins of many cases of cerebral palsy are likely to be antenatal**.
>
> ... In the near future, however, regardless of proper surveillance and new insights, in most cases of cerebral palsy there will be nothing or nobody to blame ... (emphasis added)

[40] In my judgment, the various opinions expressed in the evidence adduced from all the aforesaid medical witnesses have been somewhat divided and not unanimous. Their opinions do not show that the phenergan, fortum, dextrose and the Ryles' Tube feeding given by Dr. Mahendran was the real and substantial cause of the baby's brain damage. No liability can be established if no harm was caused in the first place, as demonstrated in and indeed confirmed by the evidence of Dr. Soh for the plaintiffs and Dr. Ng for the defendants. What and who had really and substantially caused the baby's defects as alluded to above, in particular H.I.E. with developmental delay, remains unresolved at the conclusion of the trial. I am unable to find that the plaintiffs had established causation on a balance of probabilities.

Other Issues

[41] Plaintiffs' learned counsel had expended enormous effort in raising a host of other issues. After giving them my utmost consideration, I am of the view that they are not supportive of the plaintiff's claim. Be that as it may, the learned counsel deserves a word of commendation in this regard.

Conclusion

[42] While I do sympathise with the predicament of the plaintiffs in the entire episode surrounding the birth of the baby, I am constrained to determine their claim by reference to the entire evidence at the trial.

[43] For reasons adumbrated above, I hold that the plaintiffs have failed to establish their claim against the defendants. I therefore dismiss the plaintiffs' claim with costs.